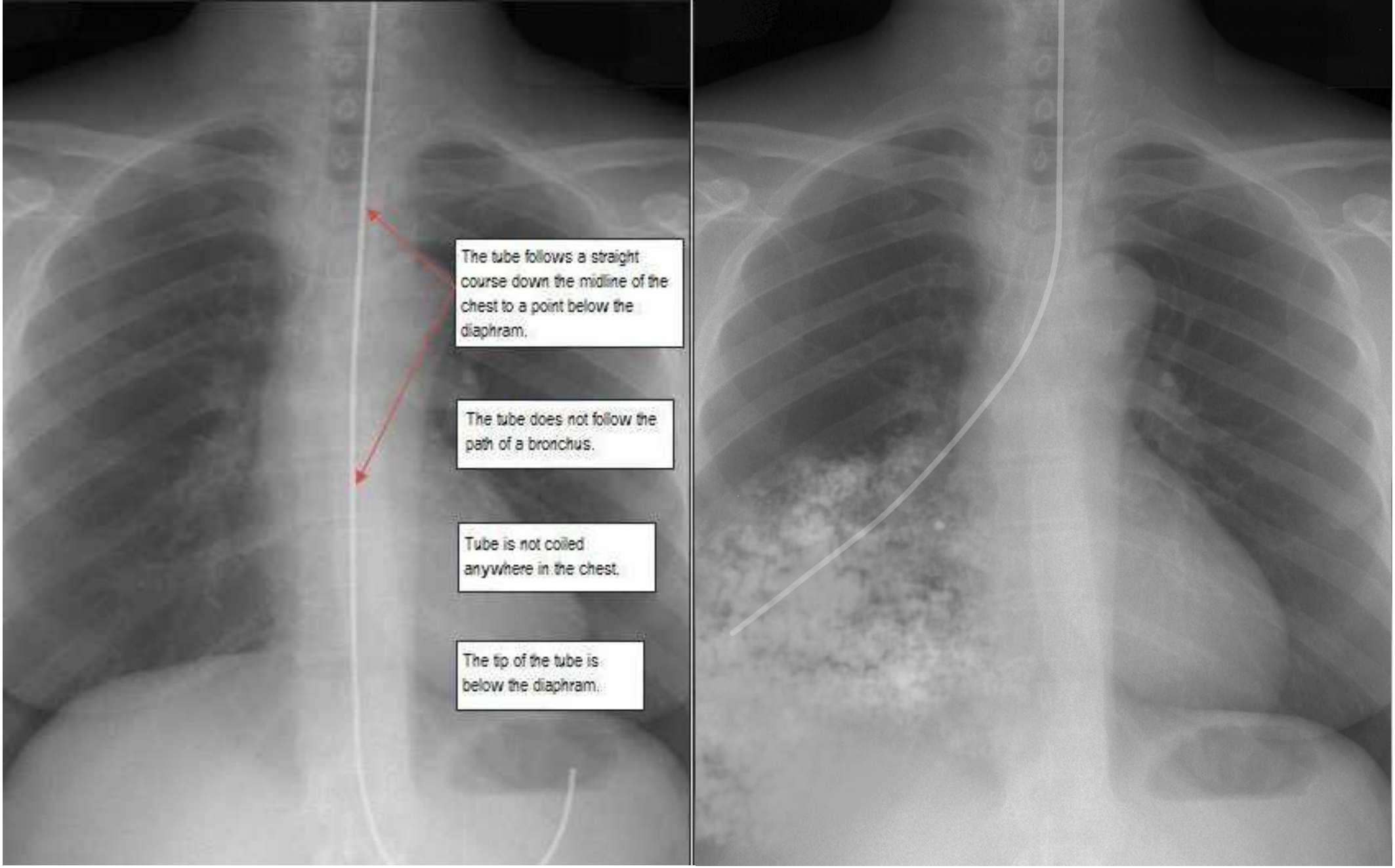


12. NG tubes, GI bleeds and intra-abdominal pressure

NGTs – Who?

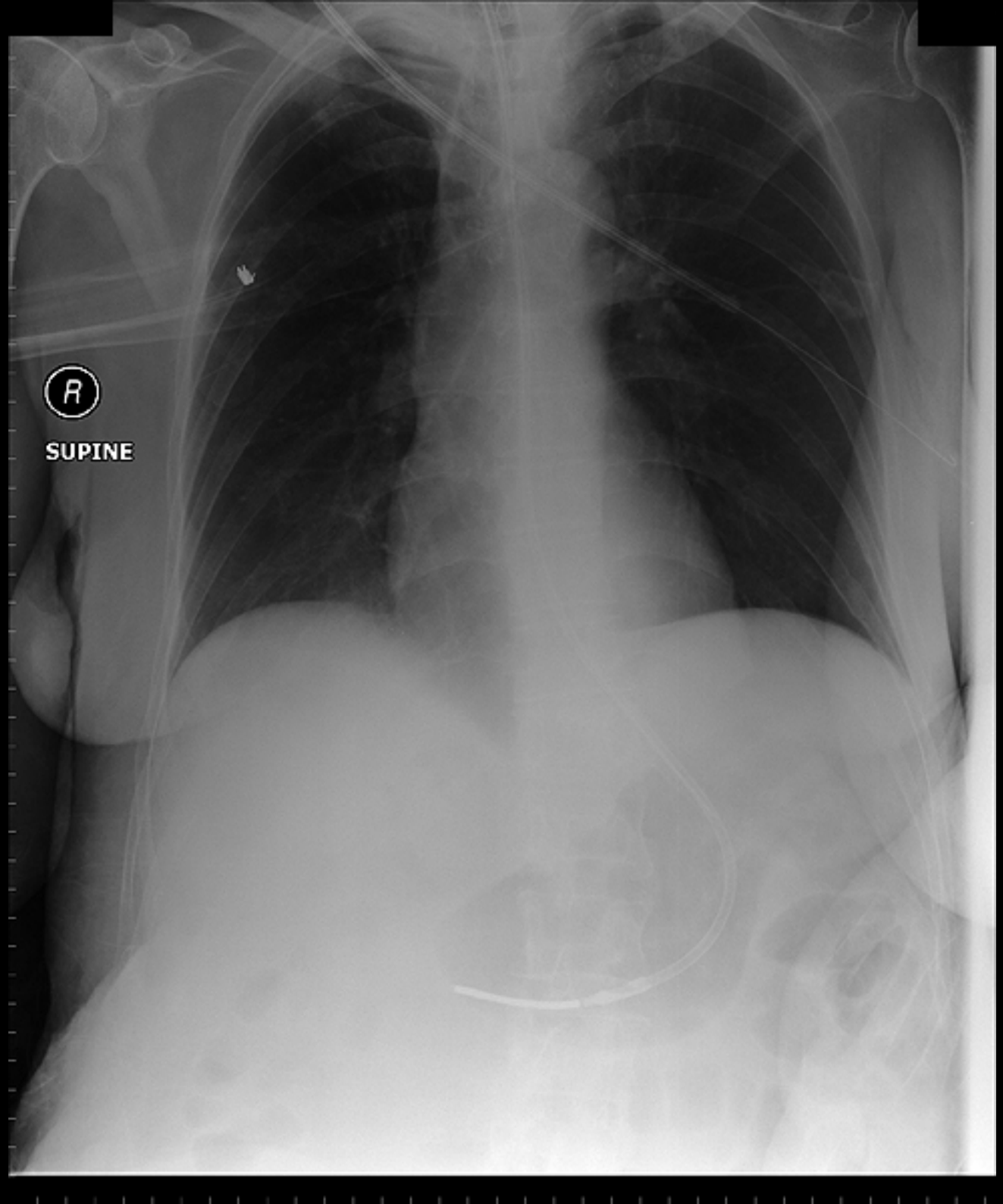
- Enteral access for food and drugs
- Presence or risk of gastric distension (air / fluid)
- All intubated patients

NGTs – How?

- Wide bore tubes should be used for decompression and in all intubated / sedated patients
- Fine bore tubes should be used for awake / long term / head and neck surgery patients
- Lubrication + /- topical LA
- Cold tube = more rigid = easier to insert
- Flex head forward
- Consider using laryngoscope & McGills (carefully)
- For problem placement try oesophageal intubation with pre-cut COETT then feed NGT through

NGTs – Checking position

- Aspirate for “typical gastric contents”
- Inject and aspirate air without resistance (epigastric “whoosh” reassuring BUT unreliable)
- Inject + aspiration of 30mls sterile water and test pH of aspirate (≤5.5 = gastric placement)
- If any doubt exists request x-ray of lower chest / upper abdomen to confirm position before use
- Remove any guide wire ASAP as if left in-situ, these stick to the tube and displace it / remove it on withdrawal.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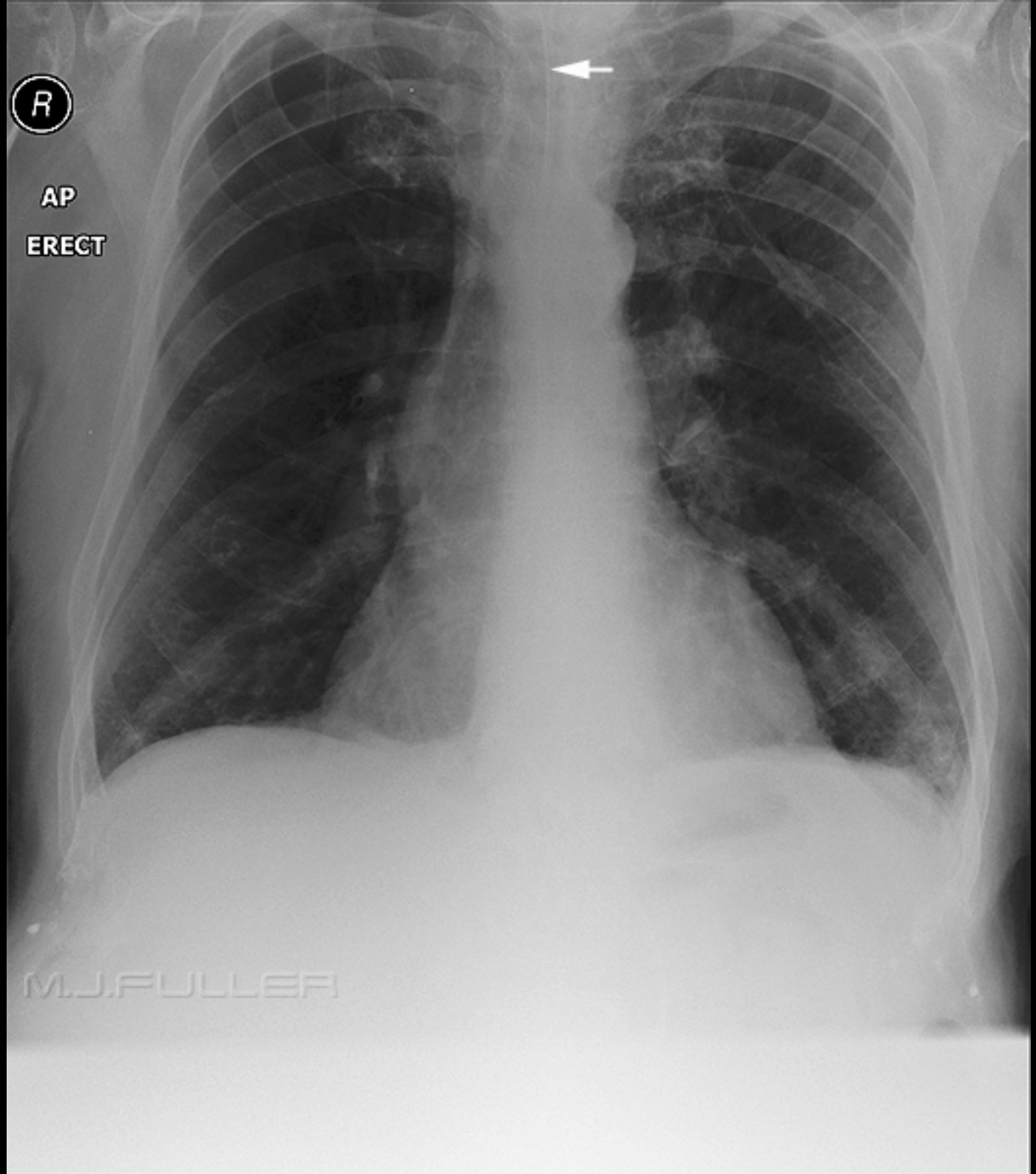
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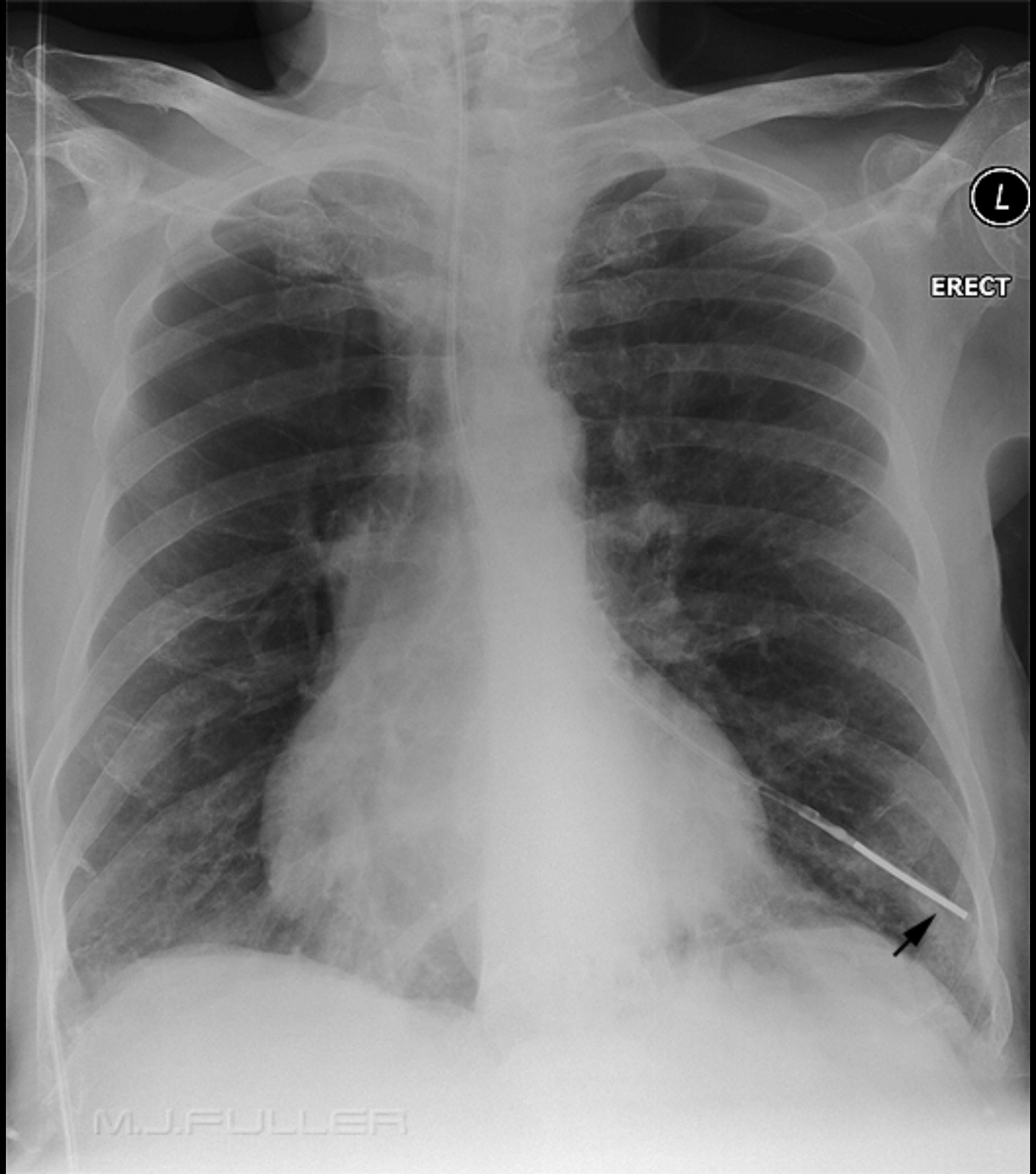
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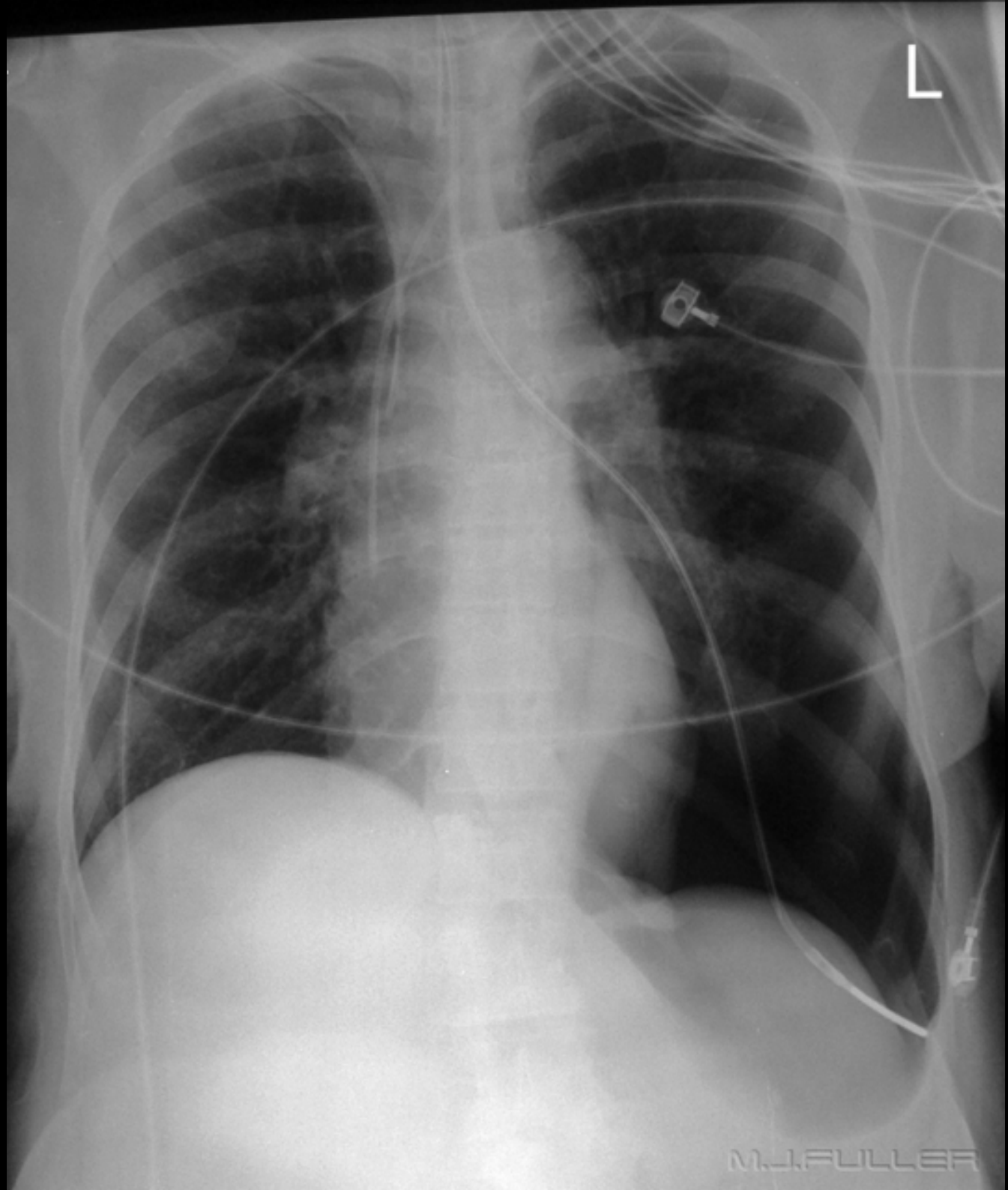
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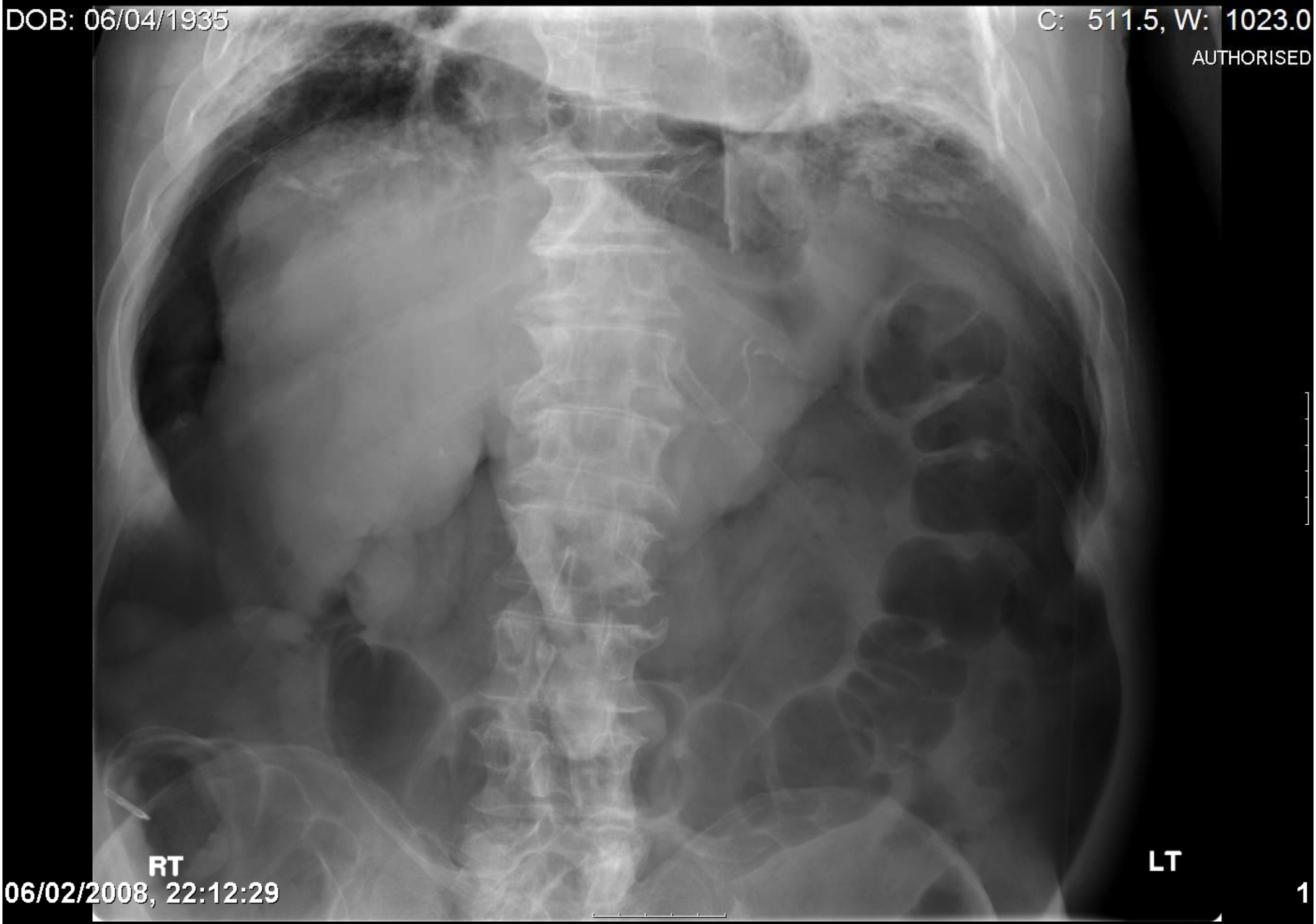
GI bleeds

- A, B, C,
- Packed RBCs / FFP / platelets
  - Vit K / cryo ppt / fibrinogen
- IV omeprazole 80mg loading then 8mg/hr for 72 hours
- Call switchboard and ask for GI bleed SpR
- Consider early referral to surgeons / interventional radiology
- Plan for the re-bleed!

Intra-abdominal pressure

- Be aware of abdominal compartment syndrome
- Regularly monitor intra-abdominal pressure in at risk patients
- Refer early for therapeutic laparostomy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